STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003930	A. BUILDING: _____ B. WING _____	05/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORTHOINDY HOSPITAL	8400 NORTHWEST BLVD INDIANAPOLIS, IN 46278

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This survey was for the investigation of one State complaint. Complaint number: IN00160643 Substantiated; no deficiencies related to the allegations are cited Date of Survey: 5/28/2015 Facility #: 003930 OrthoIndy Hospital is in compliance with 410 IAC 15-1.5-5, Medical Staff, Hospital Licensure Rules. QA: cjl 06/10/15	S 000		